Application Form for Elective Preceptorship

Student Affairs Office, Faculty of Medicine, Chiang Mai University, Thailand

110 Intravaroros road, Tumbon Sriphum, Amphur Muang, Chiang Mail 50200

Photograph

1. Name.....Gender.....
2. Date of Birth.....
3. Nationality.....
4. Address (For sending mail) .....

   .....

   Tel..... E-mail.....
5. Emergency Contact.....

   Tel.....E-mail.....
6. Contact person from home institute.....

   Position..... E-mail.....
7. Health Insurance Coverage Provided by: .....
8. Education

Date of Attendance (Medical School)		Institute	Degree	Date of Award Month/Year (Expected)
From	To			

9. Clinical Year.....
10. I Choose to Practice in the Department of:
    1. ..... From (D/M/Y) .....To.....
    2. ..... From (D/M/Y) .....To.....
    3. .....From (D/M/Y) .....To.....

    Signature of Applicant.....
11. I hereby certify that the photograph, signature and information on this form accurately apply to the individual named above:

....

Signature of Medical School Official Date

....

Official Title Institute

Medical School Seal